RULE 85
RECOUPMENT

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Section 1. Authority

This regulation is issued under the authority of Ark. Code Ann. §§ 23-61-108, 23-63-1806, 25-15-201, *et seq*., and any other applicable laws.

Section 2. Definitions

a. "Covered person" means a person on whose behalf a health care insurer offering health insurance coverage is obligated to pay benefits or provide services.

b. “Health care insurer” means an entity subject to the insurance laws of this state or the jurisdiction of the Insurance Commissioner that contracts or offers to contract to provide health insurance coverage, including, but not limited to, an insurance company, a health maintenance organization, or a hospital medical service corporation.

c. "Health care provider" means any person or entity providing:
(1) Medical, pharmacy, optometric, or dental care*;*
(2) Hospitalization; or
(3) Any other services and goods used for the purpose or incidental to the purpose of preventing, alleviating, curing, or healing human illness or injury.

d. (1) "Health insurance coverage" means benefits consisting of medical, pharmacy, optometric, or dental care, hospitalization, or other goods or services for the purpose of preventing, alleviating, curing, or healing human illness provided, directly or indirectly, through insurance, reimbursement, or otherwise, including items and services paid for under any policy, certificate, or agreement offered by a health care insurer.
(2) "Health insurance coverage" does not include policies or certificates covering only accident, credit, disability income, long-term care, hospital indemnity, Medicare supplemental policy as defined in 42 U.S.C. § 1395ss(g)(1), a specified disease, other limited benefit health insurance, automobile medical payment insurance, or claims under the Workers' Compensation Law, § 11-9-101 *et seq*., Public Employees Workers'

Compensation Act, § 21-5-601 *et seq.,* or the Arkansas Comprehensive Health Insurance Pool Act, § 23-79-501 *et seq*.

e. "Recoupment" means any action or attempt by a health care insurer to recover or collect payments already made to a health care provider with respect to a claim:

(1) By reducing other payments currently owed to the health care provider;

(2) By withholding or setting off the amount against current or future payments to the health care provider;

(3) By demanding payment back from a health care provider for a claim already paid; or

(4) In any other manner that reduces or affects the future claim payments to the health care provider.

Section 3. Time

a. Except in cases of fraud committed by the health care provider, a health care insurer may only exercise recoupment from a provider during the eighteen-month period after the date that the health care insurer paid the claim submitted by the health care provider. The exception for fraud means fraud that the insurer discovered after the eighteen-month period and could not have discovered prior to the end of the eighteen-month period by the exercise of reasonable diligence; it does not permit a health care insurer to extend the eighteen-month period under the rationale that it is still investigating a claim for fraud or any similar reason.

b. (1) A health care insurer that exercises recoupment under this section shall give the health care provider a written or electronic statement specifying the basis for the recoupment.

(2) The statement shall contain, at a minimum, the information required by Section 5.

(3) The statement shall also include notice of any right to internal appeal by the provider. If the provider initiates an internal appeal, the health care insurer shall suspend its recoupment efforts for the alleged overpayment until such time as the health care insurer has prevailed after the provider has exhausted all available internal appeals.

c. "Exercise recoupment" means the commencement of recoupment together with the provision of the statement required by Subsection 3.b. and Section 5 of this Regulation. Once recoupment has been exercised, a health care insurer may continue the recoupment to its resolution.

Section 4. Persons Not Covered

a. If a health care insurer determines that payment was made for services not covered under the covered person's health insurance coverage, the health care insurer shall give written notice to the health care provider of its intent to exercise recoupment and may:

(1) Request a refund from the health care provider; or
(2) Make a recoupment of the payment from the health care provider in accordance with Section 5.

b. (1) Except in the case of fraud committed by the health care provider or as provided in subdivision b.(2) of this section, subsection a. of this section shall not apply if a health care provider or other party on its behalf verified from the health care insurer or its agent that an individual was a covered person and if the health care provider in good faith provided services to the individual in reliance on the verification.
(2) A health care insurer has one hundred twenty (120) days from the date of payment to notify the provider of a verification error and the fact that services rendered will not be covered if the error was made in good faith at the time of the verification. If a recoupment notice is sent based upon a verification error, the health care insurer shall include a specific explanation of the error.

Section 5. Required Disclosures

If a health care insurer exercises recoupment, then the health care insurer shall provide the health care provider written documentation that specifies the:
(1) Amount of the recoupment;
(2) Covered person's name to which the recoupment applies;
(3) Patient identification number;
(4) Date or dates of service;
(5) Service or services on which the recoupment is based;
(6) Pending claims being recouped or future claims that will be recouped; and
(7) Specific reason for the recoupment. Recoupment based upon medical necessity determinations, level of service determinations, coding errors, or billing irregularities must be reconciled to specific claims and provide specific reasons for recoupment. “Specific reasons” shall not consist of mere conclusionary statements such as “not medically necessary,” but instead shall contain specific information from which the provider can determine the basis for the recoupment and make a reasoned determination about whether to challenge the recoupment. If a health care insurer recoups based on a determination that the provider billed the wrong level of care, it shall state which level of care the insurer has determined would have been appropriate.

Section 6. Violations

The failure to comply with any provision of this subchapter shall be deemed an unfair trade practice under the Trade Practices Act, Ark. Code Ann. §§ 23-66-201 *et seq.* and may be punished by the fines and penalties established under Ark. Code Ann. §§ 23-60-108, 23-66-210, and 23-66-215.

Section 7. Effective Date

This Rule shall be effective May 1, 2006. The Rule shall apply to all payments made by health care insurers to providers on or after August 12, 2005, the effective date of Act 422 of 2005.

(signed by Julie Benafield Bowman)
JULIE BENAFIELD BOWMAN
INSURANCE COMMISSIONER

(signed April 19, 2006)
DATE